

QUARTERLY PREMIUM SURCHARGE PAYMENT FORM

Insurer Name _____

Address _____

City _____ State _____ Zip Code _____

Insurer NCCI Number _____

Date of Report	Quarter Ending Date	Dollar Amount Submitted

CERTIFYING OFFICIAL (Type Name)

CERTIFYING OFFICIAL (Signature)

DATE

TITLE

TELEPHONE NUMBER

Mail Form and Check to:

D.C. Department of Employment Services
Office of the Chief Financial Officer
4058 Minnesota Avenue, NE - 5th Floor, Suite 5700
Washington, D.C. 20019
(Telephone: 202-671-1400)

Submit a Copy of the Form to:

D.C. Department of Employment Services
Office of Workers' Compensation
Post Office Box 56098, Insurance Unit
Washington, D.C. 20011
(FAX: 202-671-1929)

- (1) Checks are payable to the D.C. Treasurer.
- (2) This form may be reproduced or downloaded from the DOES website. The website address is www.does.dc.gov.